ABOUT THE PATIENT 0-12 months

Simply Health Chiropractic E5028 US Highway 14, Spring Green, WI 53588

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Parent Home Phone _____ Cell Phone _____ Gender ❑ M ❑ F

Parents' Names _____ Siblings Names and Ages _____

Parent's e-Mail Address _____ Best time to contact you? _____

Preferred way of receiving contact: ❑Phone Call ❑Email ❑Text ❑Other _____

Has your child been to a chiropractor before? ▫ No ▫ Yes If yes, Was it an Optimal Health and Wellness Chiropractor? ▫ No ▫ Yes

Name of Medical Doctor(s)_____

- I authorize the doctor or her staff to render care as deemed appropriate for my child.
- I authorize Simply Health Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the parent?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Play ❑ Daily Routine ❑ Sitting ❑ Eating

_____

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

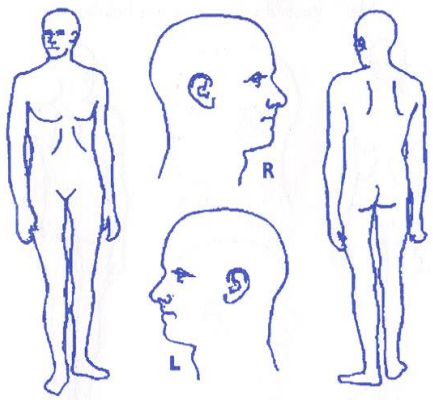
10. Results: _____

NOTES: _____

_____

_____

Please mark all areas of concern.



GENERAL HEALTH HISTORY

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Patient Name_____ *Mark the conditions that apply to your child.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Ear Infections
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Scoliosis	❑	❑	Chronic Colds/Sinus
❑	❑	Ever Needed Stitches			
❑	❑	Other _____			

Pregnancy and Birth History: Physical, Chemical and Emotional Stress

Gestational Duration:_____ **weeks** **Any Traumas or Falls during Pregnancy?** _____

Any Ultrasounds or Radiation during pregnancy? Yes / No How many / What reasons? _____

Any Invasive Procedures (eg Amniocentesis, CVS)? Yes / No

During Pregnancy, did the mother (check all that apply): ❑Smoke ❑Drink Alcohol ❑Take Prescription Medications ❑Recreational Drugs ❑Fall Ill during Pregnancy

During Pregnancy, did mother take supplements? Yes / No List all: _____

Mother's level of mental-emotional stress during pregnancy 1-10 (1=low, 10=high): _____

Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home

Birthing assistants? ❑Midwife ❑Doula ❑Obstetrician ❑Other **Was labor induced?** Yes / No

Duration of Labor? _____ **Duration of active (pushing stage) labor?** _____

Were any medications received during labor? Yes / No List medications: _____

Was there any assistance needed during birth? ❑Forceps ❑Cesarean ❑Vacuum extraction ❑Assisted traction/Head turning

Was delivery considered normal? Yes / No **If no, explain complications:** _____

Was there any evidence of birth trauma to the infant? Check all that apply:

❑Bruising ❑Odd shaped head ❑Stuck in birth canal

❑Fast or excessively long birth ❑Respiratory depression ❑Cord around neck

Was your child subjected to any of the following? Check all that apply:

❑Silver nitrate drops in eyes ❑Incubation How long? _____ ❑Vitamin K shot

❑Hepatitis shot ❑Separation from you How long? _____

Did your child spend any time in intensive care? Yes / No **If yes, how long?** _____

APGAR score at birth? _____ **APGAR score at 5 minutes?** _____

Birth weight? _____ **Birth length?** _____

Is there anything else you want us to know about the birth? _____

_____

_____

STRESSORS 0-12 months

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Because accumulation of stress affects our health and ability to heal, please answer the following questions about your child's possible childhood stressors in each category:

1. Physical stress

Does your child have a preferred sleeping position? **Yes / No.** Did/does your child prefer one-sided breast-feeding position? **Yes / No**

Did your child spit up after feeding? **Yes / No** Any falls or injuries from couches, beds, changing tables etc? **Yes / No**

Any traumas resulting in bruising, fractures or stiches? **Yes / No**

Any hospitalizations or surgeries? **Yes / No**

Does your child have difficulty with coordination? **Yes / No**

Please elaborate on questions you answered "Yes" to in the above section. _____

_____

_____

List any accidents and/or injuries: auto, sports, or other (especially those related to your child's present problems)

_____

2. Bio-Chemical Stress

Did you child breastfeed? **Yes / No** **If yes, for how long?** _____

At what age was….

formula introduced (and what brand)? _____

Cow's milk introduced? _____ Solid food introduced? _____

Does your child have food allergies? Yes / No If yes, please explain: _____

Does your child have a bowel movement daily? Yes / No If no, please explain:_____

Does your child have regular or occasional skin rashes? Yes / No If yes, please explain: _____

_____

What vaccinations were given and at what age? _____

_____

Were there any negative reactions? **Yes / No** If yes, please explain: _____

Regarding reactions, were there any: ❑Fever ❑Irritability ❑Bowel Disturbances ❑Drowsiness ❑Inconsolable crying

❑Arching of body ❑Feeding disturbances ❑Other: _____

History of Antibiotics: Yes / No If yes, how many courses of antibiotics in your child's lifetime? _____

Reason and length of last course of antibiotics? _____

Please list ALL Medications your child currently takes or has taken in the past 6 months (name, dosage, why they take/took it):

_____

Please list all nutritional supplements, vitamins and homeopathic remedies your child presently takes: _____

_____

Are there pets in the home? _____ **Are there any smokers in the home?** _____

3. Emotional Stress

Did mother have trouble breast feeding? **Yes / No** Did mother and baby have difficulty bonding? **Yes / No**

Did mother experience any post-partum depression? **Yes / No** If yes, please explain: _____

_____

Any night terrors/sleep walking/difficult sleep? **Yes / No** Is their sleep pattern normal? **Yes / No**

Quality of sleep: ❑**Good** ❑**Fair** ❑**Poor** Number of hours of sleep: _____

Any behavioral problems? **Yes / No** Do you feel your child's social and emotional development is normal his/her for age? **Yes / No**

Does your child attend daycare? **Yes / No** If yes, from what age? _____

Please elaborate on anything not covered regarding your child's emotional stress: _____

_____

GROWTH AND DEVELOPMENT HISTORY

SHC E5028 US Highway 14, Spring Green, WI 53588

1. Was your child alert and responsive within 12 hours of delivery? Yes / No If no, please explain: _____

_____

At what age did your child:

Respond to Sound:	_____	Sit alone:	_____
Follow an Object:	_____	Teethe:	_____
Hold head up:	_____	Crawl:	_____
Vocalize:	_____	Walk:	_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Do any siblings have health concerns? Yes / No If yes, explain: _____

Is there any other family history you want us to know?_____

_____

PARENTAL GENERAL HEALTH ASSESSMENT OF CHILD

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your child's:

Eating Habits: _____ Play Habits: _____ Sleep: _____ General Health: _____ Emotional Regulation: _____

How do you grade your child's Physical Health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

How do you grade your child's Emotional / Mental Health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

Is there anything else which may help us better understand your child which has not been discussed?

_____

_____

Why are you here at this point in time and what are you hoping our office can do for your child?

_____

_____

_____

I consent to a professional and complete chiropractic examination and to any radiographic examination the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____